Engaged Medical Staff: A PDPM Critical Success Factor

By Walter Lin, MD, MBA

On October 1, 2019, the Centers for Medicare & Medicaid Services (CMS) fundamentally changed the payment methodology for skilled nursing facility (SNF) post-acute care services. This switch from the Resource Utilization Groups, Version IV (RUG-IV), to the Patient Driven Payment Model (PDPM) is the biggest change to skilled nursing reimbursement in over 20 years. CMS designed PDPM with the stated major goals to “improve payment accuracy and appropriateness” by removing therapy minutes as the primary determinant of payment and “improve SNF reimbursement rate under RUG-IV for this patient would be calculated as follows:

**Case 1: RUG-IV Payment Exceeds PDPM Payment**

A 72-year-old man with a history of hypertension, diabetes, and osteoarthritis is transferred to a SNF after a hospitalization for an elective left total hip arthroplasty. Analysis. Assuming this patient receives 720+ combined minutes of therapy a week and has an ADL level of C (RUG-IV category RVC), the daily SNF reimbursement rate under RUG-IV for this patient would have been approximately $513.72, which equates to a total stay payment of $12,843. Under PDPM, the reimbursement for this patient would be calculated as follows:

**Case 2: PDPM Payment Exceeds RUG-IV Payment**

An 86-year-old woman with a history of atrial fibrillation, chronic obstructive pulmonary disease (COPD), dementia, and diabetes is transferred to a SNF after a hospitalization for a dense left-sided stroke with new dysphagia and an infected diabetic foot ulcer being treated with intravenous (IV) antibiotics.

Analysis. Assuming this patient receives 500 to 719 combined minutes of therapy a week and has an ADL level of B (RUG-IV category RUB), the daily SNF reimbursement rate under RUG-IV for this patient would be calculated as follows:

**Case Comparisons**

Note that in Case 1 the RUG-IV payment is greater because the patient is able to participate in the maximum level of therapy and did not have many medical comorbidities meriting a higher PDPM payment. By contrast, in Case 2 the PDPM payment is significantly greater because it accounts for the patient’s multiple medical comorbidities (e.g., diabetes, diabetic foot ulcer, COPD), swelling disorder, and extensive nursing services needed (e.g., IV antibiotics), which the RUG-IV payment does not.

**Implications**

The two case studies illustrate the enormous differences in reimbursement between RUG-IV and PDPM. An explicitly stated goal of PDPM is to improve SNF payments for medically complex beneficiaries, and historically care has always followed finance in the United States. As such, SNFs are expected to accept more medically complex patients under the new reimbursement system. This will have important implications.

From the facility perspective, SNFs will need engaged medical providers to care for these high-complexity patients. The potential complications in the Case 2 patient include Clostridioides difficile colitis and acute kidney injury from intravenous antibiotics, rapid ventricular response and pulmonary edema from atrial fibrillation, hyper- and hypoglycemia from diabetes, and aspiration pneumonia, mood disorders, and pressure ulcers from the stroke, just to name a few. Medical complexity heightens the imperative for appropriate advanced care planning, which results in care more consistent with the patient’s preferences. Facilities not only need engaged medical providers to assess and treat higher-acuity patients, but also require assistance in appropriate medical documentation to ensure proper payment under PDPM. This is because medical complexity under PDPM is largely defined by ICD-10 codes, and with few exceptions all these codes must be supported by documentation from either the hospital or SNF medical providers.

What does an engaged medical provider look like? Frequent presence, focused attention, and multidisciplinary collaboration in the SNF are sine qua non of medical provider engagement, as timely visits, thorough documentation, and optimal team-based patient care are otherwise very difficult to achieve. Although this is not the standard of care in most geographies, my personal opinion is that the initial history and physical should be completed within 24 to 48 hours of admission and acute changes in condition should be seen within 12 to 24 hours. This level of responsiveness may not always be possible, particularly over weekends, and yet it remains a worthy goal to strive for, especially as facility acuity increases because of PDPM. A thorough, timely initial history and physical will also help the SNF complete the all-important five-day Minimum Data Set (MDS) assessment, which sets the payment rate in PDPM for the entire stay unless an optional IPA is filed. Finally, because of the importance of accurate diagnostic codes for proper payment under PDPM, many facilities are setting up a process for coding queries and, similarly to hospitals, will expect their medical staff to respond to these queries in a timely manner.

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**Historic Change**

Under PDPM, the care provided by a physician or advanced practice provider — and accurate documentation of that care — directly impacts the SNF’s Medicare A revenue and thus financial viability. This historic change, along with the increase in medical complexity incentivized by PDPM, creates a strategic imperative for SNFs to partner with engaged medical providers who will be present, focused, and willing to work collaboratively to achieve high-quality outcomes. This disruptive change in SNF reimbursement creates a once-in-a-career opportunity for those medical providers who have chosen to dedicate their practice to this frail, vulnerable population of patients who are among the most in need of timely medical attention. PDPM is a payment model that increases the value of engaged medical staff, which, without question, is a critical success factor for SNFs under this new reimbursement system.

Dr. Lin is the founder of Generation Care Practitioners. He is a member of the Society’s Public Policy Steering Committee and of the board of directors of the Missouri Association of Long Term Care Practitioners.